

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 21 1937

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Do not use this space.

29667

1. PLACE OF DEATH

County Jackson
 Township Kan
 City Kansas City (No. Murray Hospital)

Registration District No. 399
 Primary Registration District No. 1002

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Dona Mae Hamline

(a) Residence, No. 8500-Independence Ave. St. Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 5, 1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF AAA

22. I HEREBY CERTIFY, That I attended deceased from 7-21, 1937 to 8-5, 1937

I last saw him alive on 8-5, 1937 Death is said to have occurred on the date stated above, at 6:25 a.m.

The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MARCH-19-1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
6 years 4 months 16 days

Staph. Septicemia Date of onset 7-21-37

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K6 Mo

Other contributory causes of importance:
Orchomyelitis of Right knee

13. NAME Thomas HAMLINE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KANSAS

Name of operation Incision & drainage Date of 7-23-37
 What test confirmed diagnosis? Bac culture Was there an autopsy? yes

15. MAIDEN NAME Minnie ALBERTSON

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KANSAS

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT Thomas Hamline
 (ADDRESS) 8500-Independence Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hills DATE Aug 7, 1937

Manner of injury _____
 Nature of injury _____

19. UNDERTAKER SHEIL FUNERAL HOME
 (ADDRESS) 6600-Independence Ave

24. Was disease or injury in any way related to occupation of deceased? No

20. FILED 8-7 37 M.M. Crowe ass't Registrar.

If so, specify _____
 (Signed) James R. Reed, M. D.
 (Address) 1332 Professional Bldg, Kansas City, Mo.

Was the osteomyelitis
tuberculous?

W. S. W.

Bureau of Vital Statistics

No. 222

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Keokuk Mo

Registration District No. _____
Primary Registration District No. Mercy Hospital

File No. _____
Registered No. 3301
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 8500 Indef Ave St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♂ 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED 9/7 1931 M M Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 5 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Staph. Septicemia Date of onset 7-21-37
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Other contributory causes of importance: Osteomyelitis of R knee (Pyogenic) (Not tuberculous) 7-16-37

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify C.B. Harrison M. D.
(Signed) Mercy Hosp. Keokuk Mo
(Address) Keokuk Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.